African Americans than whites. *See* Nat'l Eye Inst., *Strategic Plan on Reducing Health Disparities FY 2000-2004*, ("NEI Strategic Plan"), *at* http://www.nei.nih.gov/resources-/strategicplans/disparities.asp. Glaucoma also results in blindness for African Americans six times more often than it does for whites. *See id.* Similarly, Hispanics are two to three times more likely than whites to have diabetic retinopathy, visual problems resulting from diabetes. *See id.*

Minorities are also less likely to get treatment for visual impairment at every point in the age spectrum. For older blacks, under-treatment has been reported for cataract, diabetic retinopathy, and glaucoma. *See* B. Rahmani et al., *The cause-specific prevalence of visual impairment in an urban population: The Baltimore Eye Survey*, 103 Ophthalmology 1721 (1996); *NEI Strategic Plan* at Health Services Research. A study done in 1998 in certain Alabama public schools found that an estimated 28.3 percent of African American children needed eye care that was not being provided. *See* Janene Sims et al., *Need for Eyecare in a Minority Community* (1998). The authors attributed the excess eye care need in this minority population to lack of access, financial barriers, and a poor understanding of the importance of eye care for school-aged children. *See id.*

C. In Low-Income, Minority Communities, Lack Of Access To Eye Care Is Often A Function Of Cost

Cost is one the largest barriers to optometric care, especially for poor individuals. The AOA has estimated that more than 40 million low-income, working people in the United States cannot afford the cost of routine eye care or the health insurance that covers it. *See* AOA, Facts about VisionUSA, http://www.aoa.org/x1686.xml. Twenty-two percent of optometrists and ophthalmologists in Alabama identified financial need as the greatest barrier to eye care in their community. *See* Janet Bronstein & Michael Morrisey, *Eye Health Needs Assessment for Alabama* at 49 (2000). Like-

wise, a British study recently found that low-income individuals whose eye exams were not covered by government benefits were the least likely of all groups surveyed to have had a recent eye test. *See* J.C. van der Pols et al., *Is the Frequency of Having an Eye Test Associated with Socioeconomic Factors? A National Cross Sectional Study in British Elderly*, 53 J. Epidemiol. Cmty. Health 737, 738 (1999). Even patients with health insurance must often cover a significant portion of the cost of optometric care out of their own pockets, and are therefore affected by the cost of services. *See* U.S. Dep't of Health & Human Servs., *Visits to selected health care practitioners: United States 1980* at 10 (Pub. Health Serv. Nat'l Center for Health Statistics 1986) (finding that the patient or patient's family paid for 76 percent of the total amount paid for optometric services). Because the "prevalence of eye diseases . . . is directly associated with the accessibility, utilization, and quality of eye care services in the community," financial inaccessibility makes ocular health maintenance difficult for those in poor communities. *See* Edwin C. Marshall, *A Public Health Perspective to Clinical Health Care in Indiana*, 2 Ind. J. Optometry (1999), *available at* http://www.opt.indiana.edu/IndJOpt-/ijofall99.pdf.

Just as cost deters routine eye care for many individuals, reduction in the cost of vision services improves access to optometrists and increases the frequency of optometric visits. A 2003 study on the influence of out-of-pocket expenditures on the utilization of diabetes preventative services, for instance, found that individuals with diabetes were more likely to get annual dilated eye exams if the cost was covered by health insurance or reduced to a co-pay than if the eye exams were full-priced. *See* Andrew Karter et al., *Out-of-Pocket Costs and Diabetes Preventative Services*, 26 Diabetes Care 2294 (2003). When costs are high, low-income, minority individuals are also more likely to delay routine, non-essential eye examinations. *See id.* at 2298 (noting that "pa-

tients are more price sensitive when they perceive a health service as optional"). This delay, in turn, may aggravate existing problems or even render them untreatable. *See* Section I.A., *supra*. A reduction in the cost of optometric care is therefore an essential ingredient in improving the visual health of minority communities.

D. The Competition Provided By Corporate Optical Chains Increases Accessibility Of Optometric Care To Minority Communities By Reducing Costs And Increasing Convenience

The availability of optometric care at corporate retail optical establishments plays an important role in lower-income and minority communities. These establishments provide an easy way for minorities, who often do not have a usual source of health care, to seek visual treatment. *See* 1 *Healthy People 2010: Access to Quality Health Services* ch. 1, at http://www.healthypeople.gov/Document/HTML/Volume1/01Access.htm (describing the large numbers of minorities without a usual source of health care). Even more importantly, there is substantial evidence that commercial practice restrictions that limit the corporate practice of optometry – such as Tennessee Code § 63-8-113(c)(6) – increase consumer costs. Conversely, the presence of optometric services at retail optical chains reduces the cost of services, increasing the accessibility of eye care to minority and low-income communities.

In the mid-1970s, Federal Trade Commission ("FTC") staff began an investigation into state and private restraints on advertising of ophthalmic goods and services. After accumulating evidence that restrictions on commercial practice significantly limited competition and increased prices, the FTC decided to expand its inquiry. In two separate studies, FTC staff examined the effects of state restrictions prohibiting certain forms of lay association with optometric practices and prohibiting the practice of optometry in certain commer-

cial locations on the price and quality of optometric care and contact lens fitting. *See* Ophthalmic Practice Rules, 54 Fed. Reg. 10,285, 10,287 (Mar. 13, 1989). These studies found prices for eye exams and eyeglasses to be 18 percent higher in markets without chain firms than in markets with retail optical establishments. *See id.* at 10,288. In reciting the evidentiary record for rulemaking, the FTC concluded

> (1) That average prices for eye exams and eyeglasses are lower in markets with chain firms than in markets without chain firms; (2) that chain firms and other large-volume providers charge significantly lower prices than noncommercial providers; and (3) that each of the restrictions imposes unnecessary costs on commercial practice that impede its development and raise prices to consumers.

Id.[2]

Other studies have also considered commercial practice restrictions, concluding that they increase prices without significantly impacting the quality of eye examinations or contact lens fittings. *See* Deborah Haas-Wilson, *The Effect of Commercial Practice Restrictions: The Case of Optometry*, 29 J.L. & Econ. 165 (1986). Business practice restrictions also deter large retail optical chains from entering the market, reducing consumers' options for low-cost ophthalmic goods. *See* Deborah Haas-Wilson, *Strategic Regulatory Entry Deterrence: An Empirical Test in the Ophthalmic Market*, 8 J. Health Econ. 339, 351 (1989) (concluding that "form of practice" restrictions have been used to deter entry and maintain higher prices).

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[2] Although the D.C. Circuit later vacated the regulations issued based on these findings on the ground that the FTC lacked statutory authority to promulgate them, it did not question the factual findings on which the regulations were based. *See Cal. State Bd. of Optometry v. FTC*, 910 F.2d 976, 979 (D.C. Cir. 1990).

The FTC recently re-confirmed the conclusions drawn from empirical study of and practical experience with restrictions on optometric practice. *See* Letter to Senator Crutchfield from Timothy Muris, FTC Chairman (April 29, 2003), http://www.ftc.gov/be/v030009.htm. In response to a request to comment on Tennessee's restrictions, then-Chairman Muris observed that it was likely that the Tennessee law would reduce competition, thereby negatively impacting the prices, variety, and quality of good and services. The letter also referenced the FTC's earlier studies, reaffirming the findings that restrictions tend to drive up prices, that higher prices lead price sensitive consumers to defer seeking eye care, and that there is no evidence that the kind of restrictions at issue in Tennessee improve the quality of services. *See id.* at n.16 ("[W]e have identified no change in the marketplace that economic analysis suggests would likely reverse or eliminate the price effect if a new study were conducted with more recent data.").

In addition to reducing the costs associated with eye and vision care, the competition provided by corporate optical chains increases accessibility of optometric care to minority communities by making eye and vision care more convenient. Optical chains often are located in enclosed or strip shopping malls, or otherwise in close proximity to other retail establishments. Such a setting provides consumers with the ability to seek eye and vision care without neglecting other daily tasks. In addition, such retail-heavy locations tend to mean hours of operation that are more convenient and better suited to the schedules of those with less flexible work or childcare arrangements.

In Tennessee, where roughly a quarter of African Americans and Hispanics or Latinos live below the poverty line, entry of retail optical chains will not immediately solve the racial disparity in access to optometric services. But the competition generated by retail optical firms and the conse-

quent reduction in the cost of services, along with an increased number of optometrists, can only help to reduce visual health disparities in the underserved minority population.

II. THE PRACTICE OF OPTOMETRY IN CORPORATE RETAIL SETTINGS IS A GATEWAY INTO THE PROFESSION FOR OPTOMETRISTS AND OPTICIANS OF COLOR

Beyond improving accessibility of eye care to minority communities by decreasing cost, retail optical chains serve an important function for entry-level minority optometrists. The corporate practice of optometry allows optometrists to gain experience in their chosen practice even if they do not have a significant amount of capital or are not willing to take serious financial risks. Because many minority optometrists fresh from optometry school, facing the repayment of thousands of dollars of student loans, do not have the resources or connections necessary to begin their career in private practice, retail optical chains provide one of the few possible entries into the profession. The statute at issue in this case strips away that possibility, creating one more barrier for minorities in Tennessee interested in improving minority representation in the field of optometry.

A. The Need For Minority Optometrists

Minorities are woefully underrepresented in the field of optometry. Only about 600 of the approximately 32,000 practicing optometrists nationwide, or less than 2 percent, come from minority backgrounds. Penn. College of Optometry, Opportunities for Minorities in Optometry, http://www.pco.edu/acad_progs/Optometry/od_minorities1.htm. Nor are the rates of minority optometrists rapidly improving. Although 24 percent of 2004 optometry school graduates were Asian, only 2.4 percent were African American, only 5.9 percent were Hispanic or Latino, and only 0.3 percent were Native American or Native Alaskan. *See* Ass'n

of Schools & Colleges of Optometry, Student Profile, http://www.opted.org/info_profile.cfm.

The low numbers of minority optometrists impact both the profession of optometry and minority eye care. Minority optometrists help improve awareness of the need for optometric services within minority communities. Many individuals, especially those from underserved communities, are simply unaware of the importance of routine eye examinations, contributing to their failure to seek out or receive regular visual care. But when individuals are educated about the need for routine eye examinations or have more direct access to optometrists, they are more likely to undergo routine eye examinations. *See* Press Release, Nat'l Eye Inst., Health Education Leads to More Eye Exams in Group at Risk for Vision Loss (Dec. 6, 1999) (describing study finding that diabetic African Americans were more likely to have timely eye examinations when they were educated about the need for them and telephoned for counseling). Minority optometrists play a special role in raising the profile of optometry in underserved minority communities, acting as a bridge to patients with different values and beliefs. Studies have found, for instance, that minority physicians "serve[] disproportionately more patients of their own racial or ethnic group" and are more likely to provide health care for underserved populations in areas designated as health manpower shortage areas by the federal government. *See* Thurmond & Kirch, *supra*, at 1009-10. It follows that the dearth of minority optometrists directly contributes to the poor eye and vision care of underserved minority communities.

B. The Obstacles Preventing Minorities From Entering Optometric Practice And The Solution Presented By Corporate Optometry

The low matriculation of minority students in optometry school is a clear result of the myriad obstacles faced by minority individuals seeking to practice optometry. Some of

these hurdles are systemic; admission to optometry school requires a bachelor's degree, for instance, an educational level obtained by comparatively fewer people of color. Other barriers relate to the low numbers of minority optometrists in the field. Minority students often face "a lack of mentors, encouragement in their academic pursuits or family financial assistance before entering the program." *See* Marlee Spafford et al., *Diversity within the Profession, Part 1: Trends and Challenges*, 27 Optometric Ed. 114, 117 (2002).

Optometry school poses another serious impediment: cost. For the 2005 school year, Southern College of Optometry, the only optometry school located in Tennessee, estimated that costs for four years of education for a non-regional student would amount to around $130,000, and costs for a regional student would amount to around $110,000. *See* Southern College of Optometry 2005-2006 Catalog, Tuition & Fees, *available at* http://www.sco.edu/catalog/. Other optometry schools are similarly expensive, with tuition ranging from $11,000 per year to $40,000 per year for the four years required for optometry school. *See* Ass'n of Schools & Colleges of Optometry, Profile for 2005 Entering Class, *available at* http://www.opted.org/info_profile2.cfm. By the time they graduate, many new optometrists have accumulated $100,000 or more in student loan debt.

Facing repayment of student loans, many minority optometrists must generate some type of income reasonably soon after graduation. Immediate self-employment is often not an option for newly minted minority optometrists because of lack of experience, a shortage of contacts tied into the existing social networks, and the difficulties in obtaining the "factors that determine successful self-employment (obtaining supportive capital, developing a stable client base, community support and sufficient management training)." *See* Spafford, *supra*, at 118.

Without such contacts and access to capital to finance expensive equipment, prospects can be bleak for recently-graduated minority optometrists. This is precisely where the "turnkey" opportunities of the corporate practice of optometry are most important. The typical "turnkey" leases used in corporate practice arrangements provide not just for the leasing of physical space in the retail eyewear establishment, but also for the equipment optometrists use in their practice. The ability to lease equipment on favorable terms is indispensable for many new entrants to the profession, particularly those new entrants of color, many of whom may not have the working capital or access to capital to procure the very expensive equipment concomitant to an optometry practice.

In this situation, corporate optometry may well be the only door open to those who want to practice optometry. Like women, few minority optometry graduates begin their practice of optometry in the more lucrative private office setting. *See* AOA, *National Highlights: 2001 AOA Economic Survey* 4, *available at* http://www.optometrysmeeting.org-/documents/EconHighlights2001.pdf; Spafford, *supra*, at 117-18. Instead, minority graduates from optometry school more commonly must seek other options for practice, avoiding the unaffordable start-up costs of private practice, and the concerns over "flat revenues, decreasing market share, minimal growth of new patients, and even a loss of patients using the office" due to the uncertainty of patients and insurance programs. *See* Gary Moss & Peter Shaw-McMinn, *Why Optometrists Need to Market*, Optometry at 471 (2001).

Corporate practice also allows new graduates to practice optometry without the added preoccupation of having to sell eyewear in order to sustain a practice – a benefit crucial to the professional development of new entrants. In the corporate practice of optometry, the optometrist can leave the selling of eyewear completely to the retail establishment from which he or she is leasing space and equipment. Every min-

ute a relatively inexperienced optometrist can spend focused on patient care rather than "selling from the chair" helps to produce a diverse corps of quality eye care professionals to serve the public for years to come.

A significant portion of the NOA membership is engaged in the corporate practice of optometry, and, in the experience of NOA leadership, most students of color graduating from schools of optometry are entering the corporate practice of optometry. By providing a place where minority optometrists can join the profession without having to bear the expense of buying into or establishing a practice, the corporate practice of optometry opens doors in the profession to minorities where they otherwise would face only obstacles. Unfortunately, the restriction on the corporate practice of optometry in Tennessee Code § 63-8-113(c)(6) puts a roadblock in the path that many minorities take to gain experience in the profession. For newly graduated minority optometrists with large amounts of student loan debt, no financial resources, no experience, and few, if any, connections, this statute leaves minimal options for practice in Tennessee.

III. THE TENNESSEE STATUTE RUNS AFOUL OF THE DORMANT COMMERCE CLAUSE AND CONCOMITANTLY LIMITS THE AVAILABILITY OF EYE AND VISION CARE IN MINORITY COMMUNITIES

As the petition amply demonstrates, the Tennessee statute at issue is unconstitutional because it discriminates against interstate commerce. The statute also undermines the goals of the Commerce Clause by decreasing the availability of a vital consumer service – eye and vision care – a consequence that has the greatest adverse impact on underserved communities of color.

Promoting a free marketplace and fostering a national economy are primary purposes behind the Commerce Clause. *See, e.g., Hunt v. Wash. State Apple Adver.*

Comm'n, 432 U.S. 333, 350 (1977) (referring to "the Commerce Clause's overriding requirement of a national 'common market'"); *Wyoming v. Oklahoma*, 502 U.S. 437, 469 (1992) (Scalia, J., dissenting) (the Court's "negative Commerce Clause jurisprudence grew out of the notion that the Constitution implicitly established a national free market"). Central to this understanding of the Commerce Clause is the belief that consumers benefit when provided options in the marketplace. *See, e.g., H.P. Hood & Sons, Inc. v. Du Mond*, 336 U.S. 525, 539 (1949) ("Our system, fostered by the Commerce Clause, is that every farmer and every craftsman shall be encouraged to produce by the certainty that he will have free access to every market in the Nation, that no home embargoes will withhold his exports, and no foreign state will by customs duties or regulations exclude them. Likewise, every consumer may look to the free competition from every producing area in the Nation to protect him from exploitation by any. Such was the vision of the Founders; such has been the doctrine of this Court which has given it reality.").

The discriminatory effect of the Tennessee statute on interstate commerce decreases the availability of eye and vision care for those in underserved communities – those consumers who can least afford to be deprived of choice and affordability in the marketplace. As we have explained, the corporate practice of optometry often provides an affordable and accessible source of eye and vision care to minority communities that otherwise would be lacking. To the extent that the Tennessee statute constrains choice in the eye care market by unfairly and unreasonably restricting the corporate practice of optometry, the adverse consequences of such discriminatory conduct fall disproportionately upon minority communities. One way the statute diminishes choice in the eye care market is by largely eliminating optometry positions that do not require connections inside Tennessee or the financial resources necessary to build a practice. By restrict-

ing corporate practice, the Tennessee statute therefore creates a barrier to entry for those optometrists – those from outside the state – without ties or preexisting patients in Tennessee. It favors the optometrists already doing business in the state by increasing the expenses necessary to begin establishing a practice in the state in contravention of the Commerce Clause.

Tennessee can and should utilize available less restrictive and non-discriminatory means of achieving its purported goals in order to remain within the confines of the dormant Commerce Clause and to avoid the diminishing impact the statute has on the availability and accessibility of eye and vision care in underserved communities of color. The statute is unconstitutional – and the decision below upholding it should be reversed.

CONCLUSION

For the foregoing reasons, the petition for a writ of certiorari should be granted.

Respectfully submitted,

JONATHAN D. HACKER
(Counsel of Record)
SHANNON M. PAZUR
O'MELVENY & MYERS LLP
1625 Eye Street, N.W.
Washington, D.C. 20006
(202) 383-5300

Attorneys for Amicus Curiae

January 3, 2006